TELEHEALTH TASK FORCE (TTF) MEETING AGENDA

Virtual Meeting Information - Join Zoom Meeting
https://jubengineers.zoom.us/j/98731231705?pwd=UjRsWk1lSm9yUEQxL1RESWJtMDU3QT09
Meeting ID: 987 3123 1705 Password: Telehealth
Phone audio 19294362866# or 198731231705# (US) Meeting ID: 987 3123 1705#

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Wednesday, May 27, 2020, 9:00 AM-12 NOON MST

TIME	AGENDA ITEM	*OBJECTIVE*
9:00 a.m.	**Welcome & Introductions – Jenni Gudapati, Co-Chair** ☐ Welcome, Introductions, Roll Call, Overview of TTF Role – Jenni Gudapati ☐ Review of Department Policy regarding Vendor Neutrality – Mary Sheridan ☐ Action Item: Approval of Minutes of April 29, 2020 Task Force Meeting – Jenni Gudapati	*Meeting Overview*
9:20 a.m.	**Subject Matter Expert Presentation –** Dr. Brooke Fukuoka, DMD, Your Special Smiles Dental Teledentistry Pilot Project	*15- minute video presentation 5-minute Q & A*
9:40 a.m.	**Subject Matter Expert Presentation –** Ann Mond Johnson, CEO, American Telemedicine Association	*10-minute presentation 10-minute Q & A*
10:00 a.m.	**Subject Matter Expert Presentation –**Matt Bell, Regional Vice President of Idaho and Hilary Klarc, Director of Provider Network, PacificSource	*10-minute presentation 10-minute Q & A*
10:20 a.m.	**Break**	*10-minutes*
10:30 a.m.	**Subject Matter Expert Presentation –** Julia Millard, Head of Partner Success, Bright MD	*10-minute presentation 10-minute Q & A*
10:50 a.m.	**Subject Matter Expert Presentation –** Dr. Sarai Ambert-Pompey, a General Internal Medicine Physician practicing in Boise, Idaho at the Department of Veterans Affairs	*10-minute presentation 10-minute Q & A*
11:10 a.m.	**Subject Matter Expert Presentation –** Dave Hays, Health Program Specialist, Community Health Emergency Medical Services (CHEMS) Program, Department of Health and Welfare, Bureau of EMS, Division of Public Health	*10-minute presentation 10-minute Q & A*

TIME	AGENDA ITEM	*OBJECTIVE*
11:30 a.m.	**Identify Action Items and Next Steps – Krista Stadler, Co-Chair** □ Key questions for next steps □ Identify action items and follow-up needed	
12:00 noon	**ADJOURN**	

TeleT

Telehealth Task Force

May 27, 2020 On Line Meeting
9:00 a.m. Mountain Time

Action Items:

Action Item 1 – April Telehealth Task Force (TTF) Meeting Minutes

TTF members will be asked to adopt the minutes from the April 29, 2020 TTF meeting.

Motion: I, _____move to accept the minutes of the April 29, 2020 meeting of the Telehealth Task Force as presented.

Second: _____

TeleT

Telehealth Task Force

April 29, 2020 at 9:00 am **Location: Virtual Meeting Via Zoom**

Meeting Minutes:

Member Attendees: Craig Belcher, Aleasha Eberly, Eric Forsch, Eric Foster, Doug Fry, Jennif Gudapati, Chad Holt, Susie Pouliot and Krista Stadler

Ex Officio Members: David Bell (absent)

Members Excused: Patrick Nauman
Members Absent: Paul Coleman, Rick Naerbout

Guests on Phone: 48 guests in attendance

DHW Staff: Mary Sheridan, Ann Watkins, Stephanie Sayegh, Matt Walker

Summary of Motions/Decisions:

Motion:	**Outcome:**
Alesha Eberly moved to accept minutes of the February 26, 2020 meeting of the Telehealth Task Force as presented. Doug Fry seconded the motion.	**Passed**

Agenda Topics:

Welcome and Opening Remarks; Roll Call; Introductions; and Agenda Review- *Craig Belcher, Co-Chair*

- Craig Belcher lead roll call, introductions and review of the agenda.
- Krista Stadler, Co-Chair explained that there are a few outstanding action items, including data collection that has been requested by Task Force members. Ann Watkins, DHW, stated that this information will be shared out soon.

Presentation by - *Francoise Cleveland, AARP Idaho*

Francoise Cleveland is the Associate State Director of Advocacy for AARP Idaho. Francoise shared that AARP is invested in advancing telehealth services for its members, as it can help prevent unnecessary hospitalizations and allow individuals to remain in homes longer. Telehealth can also support family caregivers by bringing specialty care into the home and allowing caregivers to participate in long-distance medical visits.
HB 342 and COVID-19 waivers have set the stage for increasing flexibility and removing barriers to telehealth through services such as remote patient monitoring and prescription orders. In order to continue to advance the use of telehealth, Francoise recommends that Idaho expand access to broadband, engage in outreach to providers, and support patient advocacy groups to represent the consumer voice.

Questions included:

- Can you expand on what we need to establish the provider-patient relationship?
    - Provider flexibility to determine which platform is best for individual patients
- *Do you have more details as to what would be included in the "expanded" language?
- *What are the challenges our older individuals are experiencing with telehealth?
- *What actions are being taken to get better broadband coverage?

Presentation by - *Paul Glassman, College of Dental Medicine at California Northstate University*

Paul Glassman is the Assistant Dean for Research and Community Engagement at the College of Dental Medicine at California Northstate University. Paul provided information on the key systems necessary for a successful "virtual dental home." Strategies promoted included changing incentive and delivery systems, as well as measurement and payment systems. Prevention is emphasized, and consultations and services can be completed by a dental hygienist. Paul is currently working with Misty Robinson with the Idaho Department of Health and Welfare on a pilot project to implement a local telehealth dentistry system to improve care for people within the community.

Paul provided the Teledentistry Resources and Policy Guidance, and directed Task Force members to suggested teledentistry rules, found in meeting packet.

Questions included:

- What specific barriers are you seeing in Idaho, and what are your recommendations for addressing them in a post-COVID world?
    - Dental services occur in a higher risk environment for airborne infections. Worldviews of dentists will need to be changed, which can be accomplished through pilot projects. Clear rules and regulations and scopes of practice will need to be communicated, particularly around what services can receive compensation. Parity in payment is important.
- Are there any analogous learnings between teledermatology and teledentistry?
    - It can work similarly. A picture is often not enough information for a dentist to conduct a full evaluation. This is why a dental hygienist is critical to support activities such as collecting records and looking for soft tissue abnormalities to present to the dentist.

Presentation by – *Trudy Bearden, CoMagine Health*

Trudy Bearden is a senior consultant with CoMagine Health. She provides technical assistance to support practice transformation. Trudy shared information on the Rapid Response Telemedicine Teams that have been formed to provide technical assistance to providers during the COVID-19 public health crisis. Medicare virtual care services being offered range from e-visits and telephone evaluations and monitoring, to remote physiologic monitoring and behavioral health support. Telemedicine strategies are currently focused on what is needed to address gaps emerging from COVID-19 impacts, but these strategies will pivot toward advocacy, education, sustainability, and alignment needs once the public health emergency is over. Tracy offered a number of additional considerations that must be taken into account in order to ensure the future success of telehealth, including issues of equity, privacy, and parity in reimbursement.

Questions included:

- How will Medicare evaluate what services they maintain post COVID-19?
    - While hearing from the front lines that expanded access is important, concerns regarding potential fraud and abuse will likely drive certain decisions. HIPAA requirements will likely be reinstated. Ability to use smart phones will be explored as it addresses the access issue.
    - It will be important for this group, as well as state leadership, to show how telehealth addresses provider shortages in rural areas, increases access to healthcare, and provides cost-effective services.
- What are your thoughts on using telehealth to address the limited number of providers in the Treasure and Magic Valley?
    - We should all advocate to maintain the expanded use of telehealth as an additional tool in the toolbox to increasing access to care, even in metro areas.
- What are the barriers to using telemedicine across state lines?
    - Idaho Medicaid and CMS have guidelines for addressing services across state lines, as state regulations do differ.
    - Healthcare provider licensure is one barrier. It has been relaxed during the pandemic, but most licensure boards want jurisdiction over care that is provided in their own state to allow them to fulfill their role in protecting the public.
    - One of the CMS waivers is: "Waives requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. Must meet four conditions: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state which relates to his or her Medicare enrollment; 3) is furnishing services — whether in person or via telehealth — in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and, 4) is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area." https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf
        - Krista Stadler strongly advises review the rules of each state related to telehealth emergency licensure. The states have jurisdiction over licensure and have individual requirements and processes. We have seen that CMS's statement has caused some misperceptions among providers.

Presentation by - *Rachelle Williams, Idaho State University*

Rachelle Williams is an Assistant Professor in the Department of Dental Hygiene at Idaho State University. Rachelle shared information on the University's Dental Hygiene Teledentistry program, which has begun providing services to assisted living centers and nursing homes. One of the biggest barriers to expanding teledentistry, Rachelle explained, the current lack of interoperability of software systems. Ideally, dental hygienists would be able to connect to the patient's health records either through their electronic health record software in order to understand the patient's health considerations and communicate needs from an oral health perspective. Another challenge is the current inability to receive reimbursement for many services.

Questions included:

- Have you explored the Idaho Health Data Exchange and do you have recommendations on how this platform could be useful?
    - Not yet. Rachelle will connect with Mary Sheridan and Ann Watkins on this.

Presentation by - *Dr. Waseem Ghannam, TeleHealth Solution*

Dr. Waseem Ghannam is the CEO and Co-founder of TeleHealth Solutions. Dr. Ghannam shared a case study on utilizing telehealth in skilled nursing facilities and critical access hospitals and how a "treat in place" approach can reduce readmission rates and improve clinical outcomes.

Questions included:

- What are the specific barriers you see in Idaho and what should we do to address them?
    - A fear of adoption. A state university or healthcare provider group should drive this initiative to establish trust and legitimacy. Lack of adoption of technology by patients is not the challenge – it's the lack of adoption by providers.
- What would prevent rural hospital or clinics from doing this now? Do you have states that are doing this already?
    - This process is being adopted in Oklahoma, Wisconsin and North Carolina. Process allows smaller hospitals to keep patients in the community.

Presentation by - *Neil Tantingco, Connected Home Living*

Neil Tantingco is the founder of Connected Home Living, which provides remote care monitoring services to health systems. Neil described the services provided through Connected Home Living and explained that the primary benefit was the increased connection patients have to providers and medical staff. The Hospital-to-Home program and the Community Transition program are two examples of how the company embeds technology into the patient transition process to expedite coordination times and improve quality of care.

Questions included:

- Is your reimbursement model through hospitals and ACOs rather than fee for service?
    - Correct. This allows us to reduce costs and identify savings through reduced readmissions.
- What specific recommendations do you have for Idaho to reduce some of the barriers that you may encounter when developing a new program or partnering?

- The payment model needs to be adjusted. Regulations need to be relaxed to allow home nurses to work beyond state borders. Need to incentivize patients to adopt the use of technology.

Presentation by - *Madeline Russell, Lost Rivers Medical Center*

Madeline Russell is the Director of Quality at Lost Rivers Medical Center. Madeline shared her perspective from a critical access hospital on the opportunities and challenges of trying to implement telehealth in rural communities. These key barriers include lack of parity in payment models, resistance from providers to adopt new processes that are not in person, and the lack of access to reliable broadband in rural areas. Madeline's recommendations for addressing these barriers was to continue to work with payers to develop an equitable and transparent payment model, and broad education and outreach to medical staff on how to integrate telehealth into existing services.

Questions included:

- In terms of training staff on how to bill appropriately, what resources have you found are most effective to garner full reimbursement?
  - The Bureau of Rural Health has been helpful.
- Is there more complexity with commercial payers?
  - Yes
- Is the urban vs. rural telehealth location requirements a barrier? Would that have helped with billing clarification?
  - Because we were aligned with the metro area of Idaho Falls, we were unable to explore a joint-venture arrangement with another critical care access hospital.

Follow-up Items for Next Steps- *Krista Sadler, Co-Chair*

- Krista Stadler requested that Task Force members reflect on the lessons learned in implementing telehealth services in the midst of the public health emergency and share them with Ann Watkins as a resource to draw from as the group begins to develop specific recommendations.
- Trudy Bearden and Co-imagine Health will send bullet point recommendations to Ann Watkins about what CMS regulations (adopted during COVID-19) would be helpful to continue post public health emergency.
- Rachelle Williams will reach out to Bureau of Rural Health for assistance connecting to Idaho Health Data Exchange to explore opportunities to share patient information.
- Ann Watkins will work with Eric Forsch at the Department of Commerce to gather information on state efforts to address access to broadband.

Meeting Adjourned: 12:00 p.m. MST

Next Meeting: May 27, 2020 from 9 a.m. – 12 noon MST

BIO

Dr. Brooke Fukuoka established Your Special Smiles in May of 2015, with the mission of increasing the quality of life for adults who have special needs and geriatric patients who have limited mobility. In collaboration with St. Luke's physicians, she has developed a program that provides dental care and preventative screenings under anesthesia to a host of patients who have special needs.

Dr. Fukuoka completed her residence at the University of Louisville Hospital.

27 May 2020

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Dr. Brooke Fukuoka will present a video on Your Special Smiles Teledent Program - the link to the video is here: https://www.facebook.com/yourspecialsmiles/videos/688552478603811/

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Telehealth Task Force
Use Case Name: Your Special Smiles PLLC
Presentation Date: May 27, 2020

Presenter: Dr. Brooke MO Fukuoka
Presenter Email: yourspecialsmiles@gmail.com (Please no subscriptions)

Use Case Description:
Utilizing teledentistry, portable dentistry, and silver diamine fluoride to expand access to dental care for adults who have special needs and geriatric patients who have limited mobility

Accomplishments and Quick Wins: (Assuming this group is only interested in those related to teledentistry)

- We have patients who would otherwise not have access to care now do.
- We have patients who previously had to be treated under general anesthesia now are able to be treated awake.
- We were able to continue some connection and care with high risk populations during the coronavirus pandemic.
- We are able to improve our performance by improving our visualization of the area
- We are able to improve daily oral hygiene though video consultations
- Distribution of information:
    - Your Special Smiles team gave course on mobile and teledentistry at the National Mobile Dental Conference
        - No link available – paid registration only per conference rules
    - "Practical Aspects and Examples of Teledentistry" – online CE course presented live and recorded in cooperation with the Southern Arizona Health Coalition and Dr. Scott Howell, DMD, MPH, FSCD. March 2020 https://us02web.zoom.us/rec/share/9dNTd5fSyERLT6OQzB_0e7cvELnneaa80SFI-fVZnUomeTyho3-r3zp1JxH15SNp

- "Managing Dental Emergencies, Controlling Caries, and using Teledentistry and SDF" pre-recorded online CE in partnership with Elevate Oral Care http://www.elevateoralcare.com/FukuokaCE?fbclid=IwAR3r0XfSd6Q9tM0B7gja1Yi7QkCA_9Hl_93cA5ys1Igd0YCkPR0PIUlkMYw
- "Talkin' Teledentistry" Guest speaker with Drs. Brian Novy and Erinne Kennedy. http://mpefund.org/teledentistry
- "Treating and Preventing Oral Disease Through Locked Doors and Beyond" – online CE course live and recorded in cooperation with Elevate Oral Care. April 2020- not yet out for recorded viewing

Best Practices, Lessons Learned and A-Ha Moments (lessons learned):

- Sometimes you NEED asynchronous teledent to get quality images
- Some rooms in a long-term care facility the internet doesn't work well
- Google chrome does not have a windows operating system…≠ PD ≠ MAC
- Not everyone knows what proper PPE is…
- Some programs don't record interactions
- Child blockers are useful, and may come across disrespectful
- Our team is super smart, I am very impressed with them.
- **ALL** long-term care facilities should have and be trained with intraoral cameras

Barriers and Challenges:

- Internet and "IT" issues
- Infection control for non-staff members
- **REIMBURSMENT FOR ASYNCHRONOUS**
- **REIMBURSEMENT BEFORE COVID**
- **REIMBURSEMENT AFTER COVID**

What is your magic wand scenario?

- Medicaid and other third-party payers to reimburse for services provided through asynchronous and synchronous teledentistry.
- Online CE for providers -teaching our workflows and how they can apply to ordinary practice
- Hands on CE for providers
- Establish a network of providers who are willing to do teledental exams and have patients transported to their office if needed.
- Establish a network of portable and mobile providers
- Bring "Teledental Kits" to ALL long-term care facilities and have annual formal training on how to use, and proper infection control.
- Have Third party fund ALL long-term care facilities to have teledentistry platform subscription such as mouth watch teledent.

- Public information distribution (after providers lined up and after facilities have systems) Make it commonplace for nursing homes to have the “dental camera” – just as common as the “med cart”
- Encourage utilization of expanded access hygienists under general supervision after medical history review from dentist or MD.

Recommendations:

Help us make the “magic wand scenarios” become realistic.

BIO

Ann Mond Johnson was named Chief Executive Officer of the American Telemedicine Association (ATA) in February 2018. Prior to that appointment, she served as CEO of Zest Health. Previously, she served as Board Chair and Advisor to ConnectedHealth, a leading provider of private insurance exchanges. In 2000, she co-founded and served as CEO of Subimo, a pioneer in healthcare cost and quality transparency tools for consumers.

With 25 years of healthcare leadership and entrepreneurial experience, Mond Johnson's background includes launching, building and leading companies that have been innovators in using health care technology and data to improve consumer experience and maximize consumer benefit.

27 May 2020

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Idaho Telehealth Task Force Presentation from the ATA

May 27, 2020

We have the unique perspective of understanding the continuum of needs and possibilities across the market and believe telehealth and virtual care have the ability to improve access while providing a safe, appropriate and cost effective service.

OUR VISION

We’re here to ensure that people get care where and when they need it, and when they do, they know it is safe, effective and appropriate while enabling clinicians to do more good for more people

OUR FOCUS

The ATA's vision can best be achieved by focusing on institutions as the point of influence in driving adoption and normalization within the industry. An orientation that creates institutional value in advancing telehealth will have a broader impact

OUR WORK

We draw on a diverse and active membership

Education and networking are hallmarks

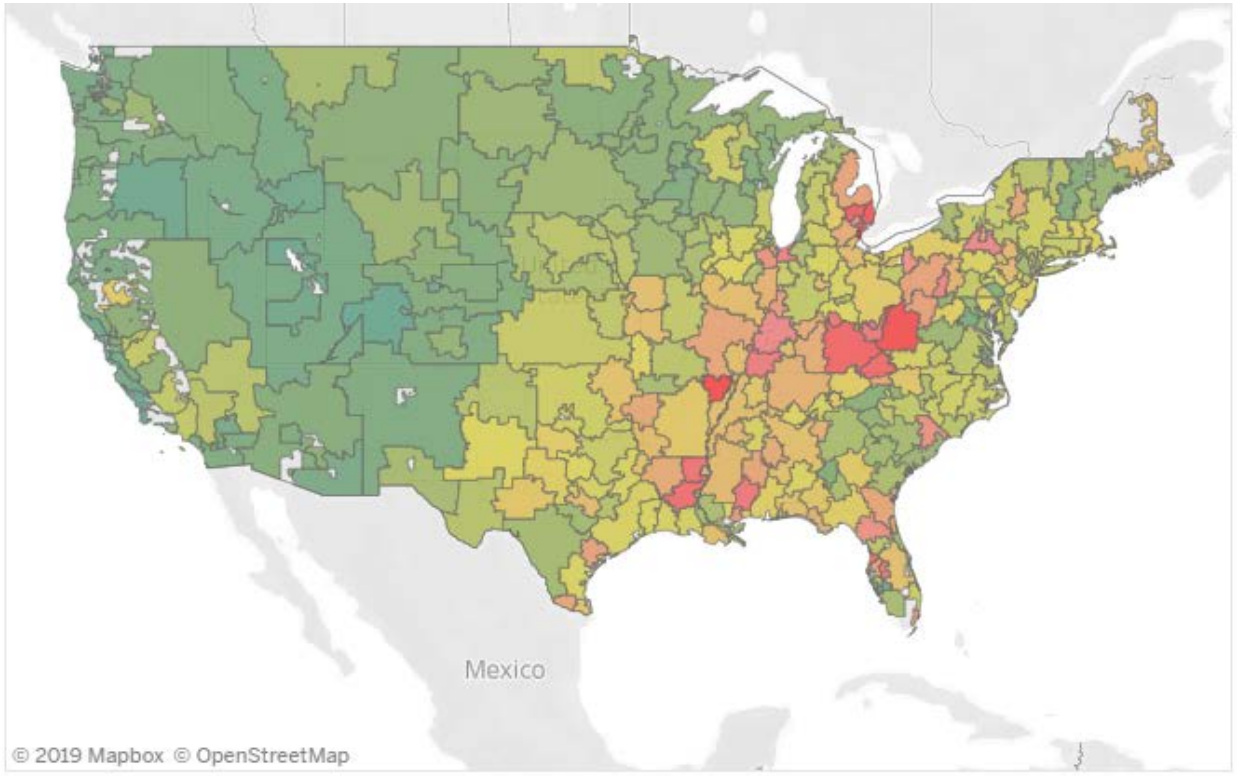
SIGs advance practice guidelines and problem solve

Initiatives focus on time sensitive topics

Policy and advocacy at the Federal and state levels

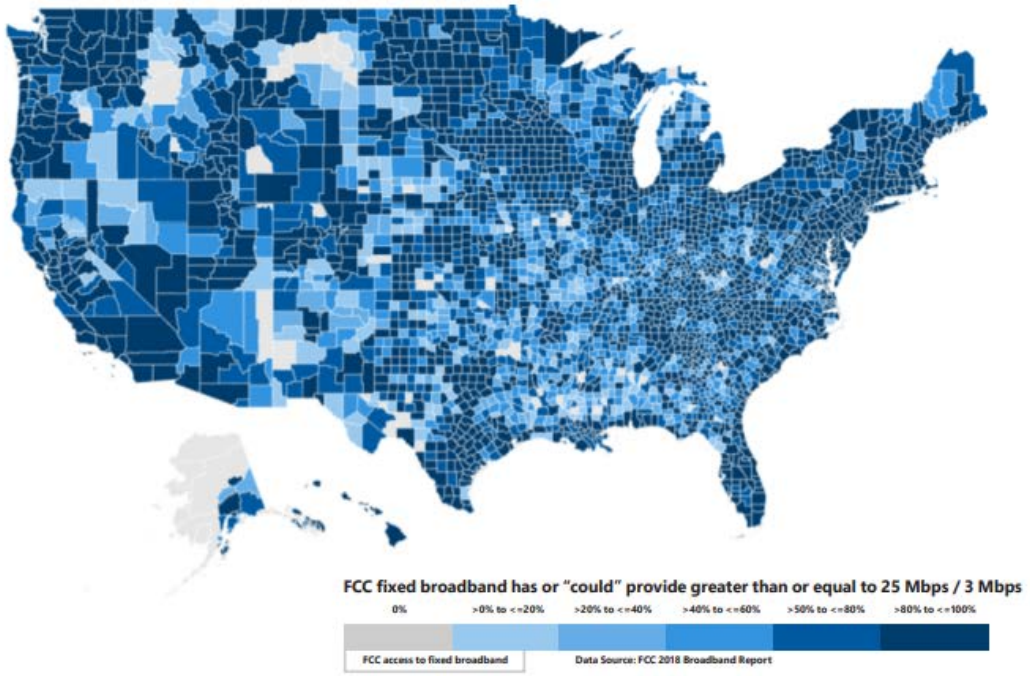
CHALLENGES PRE COVID-19

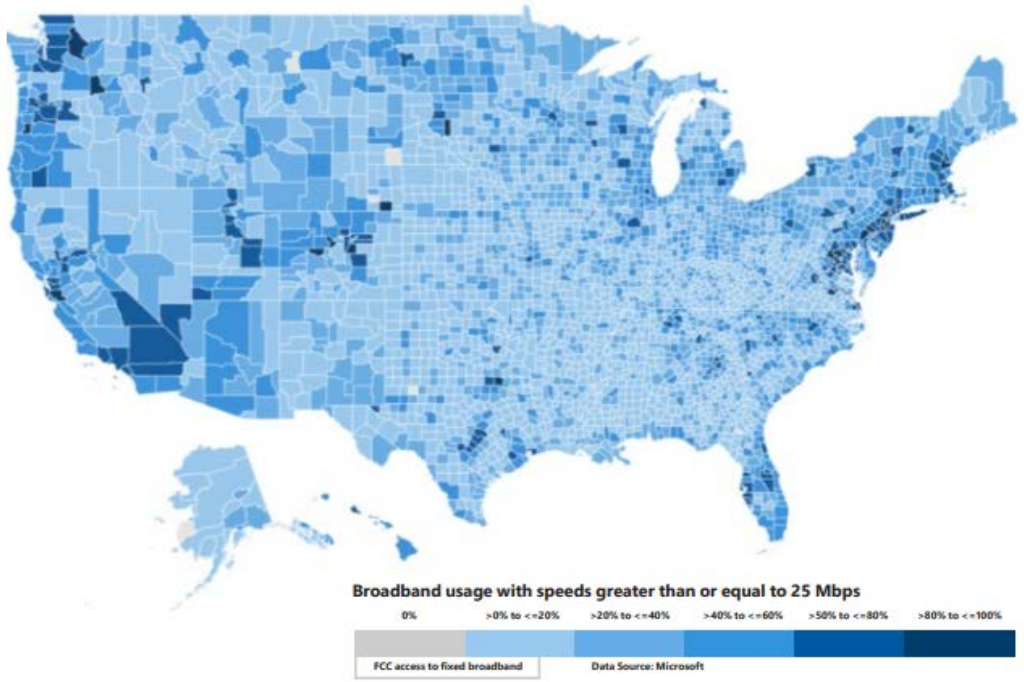
VARIATION IN COST AND TREATMENT



https://www.dartmouthatlas.org/interactive-apps/medical-discharges/

INADEQUATE ACCESS TO BROADBAND





GROWING SHORTAGES OF PRIMARY CARE PHYSICIANS

An estimated 65 million Americans now live in “a primary care desert,[1]” where the total number of Primary Care Doctors (PCP) can only meet 50% or less of the population’s needs. By 2025, the Association of American Medical Colleges projects U.S. shortages of PCP’s will increase significantly.

HEALTHCARE SPENDING CONTINUES TO GROW

The U.S. Center for Medicare and Medicaid Services (CMS) estimates that, with an aging population, total U.S. healthcare spending will increase by 5.8% per year between 2018 and 2025, and constitute 19.9% of U.S. GDP in 2025.

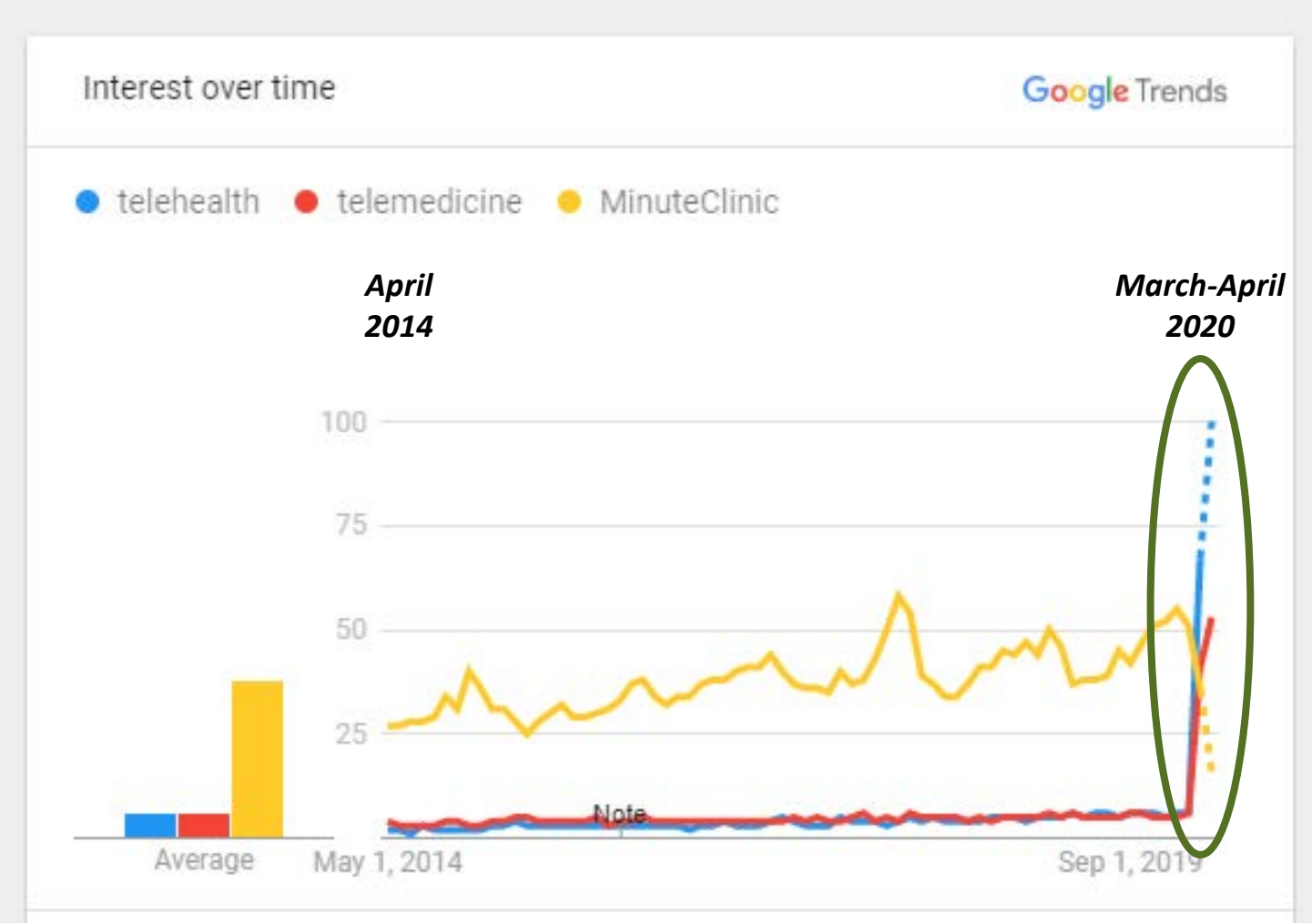
MARKET PENETRATION

In 2016, telemedicine providers achieved a market penetration of less than 0.5%, reflecting an estimated 1.25 million telemedicine consultants of this 400+ million potential consults.

THIS IS NOW

There has been a huge spike in interest/searches for telemedicine & telehealth over the last 4 weeks.

Searches For "Telehealth," "Telemedicine" & "MinuteClinic"
(April 2014 – March/April 2020)



Source: Google Trends

PUBLIC OPINION STRATEGIES

And, the media is closely tracking that spike in interest in telemedicine.


THE WALL STREET JOURNAL.

BUSINESS | HEALTH CARE | HEALTH

Telemedicine, Once a Hard Sell, Can't Keep Up With Demand

The new coronavirus outbreak is testing the industry's capacity, sending companies scrambling for doctors and new services

By Parmy Olson

April 1, 2020 5:47 am ET


abc NEWS

Telemedicine is having a moment. How can patients make use of the growing industry?

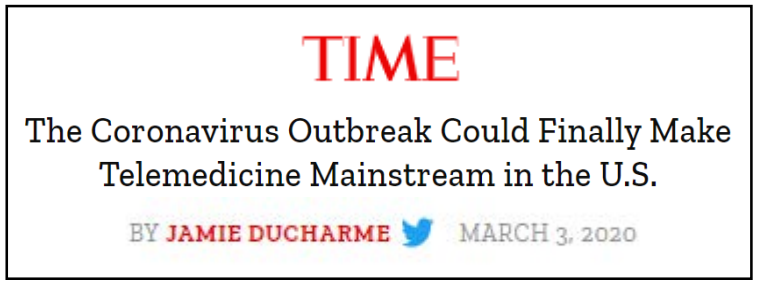
By **Lucien Bruggeman**

March 23, 2020, 3:59 AM • 10 min read


The Economist

Telemedicine is essential amid the covid-19 crisis and after it

Mar 31st 2020


TIME

The Coronavirus Outbreak Could Finally Make Telemedicine Mainstream in the U.S.

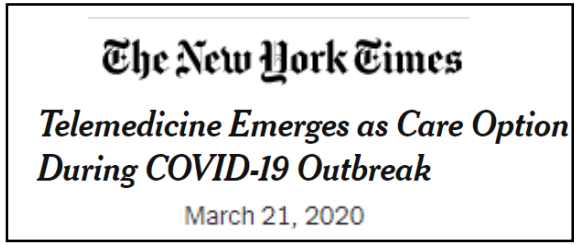
BY JAMIE DUCHARME MARCH 3, 2020


TODAY

People are using their phones to see a doctor. How does it work?

March 19, 2020, 4:07 PM EDT

By Vivian Manning-Schaffel


The New York Times

Telemedicine Emerges as Care Option During COVID-19 Outbreak

March 21, 2020


CNN

The doctor will see you now...in your living room

By Paul R. La Monica, CNN Business

Updated 2:57 PM ET, Wed April 1, 2020


The Boston Globe

Coronavirus should be a testing ground for telemedicine's potential

Updated March 29, 2020, 4:00 a.m.

HARBINGER OF THINGS TO COME?

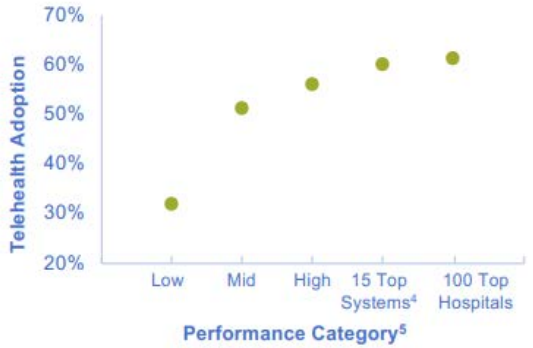
Providence	20 – 30x increase
Mass General	10 – 20x increase
Jefferson	10x increase in one week
NYU Langone	0 to 5,500 virtual visits in one day
Sutter	175x increase
Zipnosis	590 visits per day to 75,000 per day
Teladoc Health	100,000 visits in one week

TELEHEALTH ADOPTION TIED TO HOSPITAL PERFORMANCE

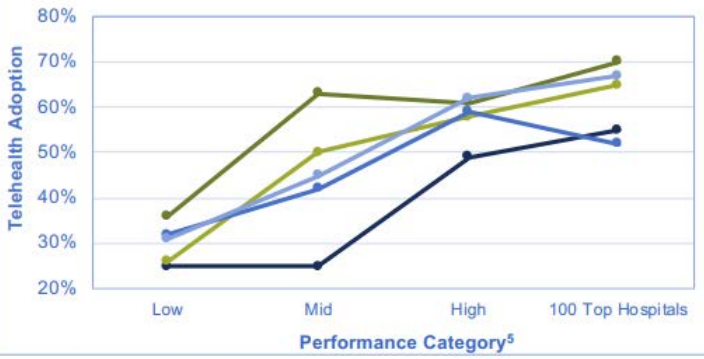
Telehealth Adoption is Higher at Better-Performing Hospitals

It is clear that adoption of telehealth continues to grow. According to the American Hospital Association, the number of hospitals fully or partially implementing computerized telehealth systems increased from 35% in 2010 to 76% in 2017.*[1]

To understand whether **telehealth is associated with hospital performance**, the American Telemedicine Association (ATA) and IBM Watson Health analyzed 2,785 US hospitals in the 100 Top Hospitals program.[2, 3]



The Adoption-Performance Relationship Varies by Hospital Class



...but, higher performing hospitals are still more likely to use telehealth.

- Small Community
- Med Community
- Large Community
- Minor Teaching
- Major Teaching

Impact Where it Counts: Telehealth Is Associated With Better Clinical Outcomes

Increase in Performance Percentile for Hospitals with Telehealth

The data show **statistically significant** correlations between risk-adjusted mortality and complication rates and hospital adoption of telehealth, controlling for hospital class.[6]

CHALLENGES POST COVID

Post COVID

Regulatory and legislative priorities

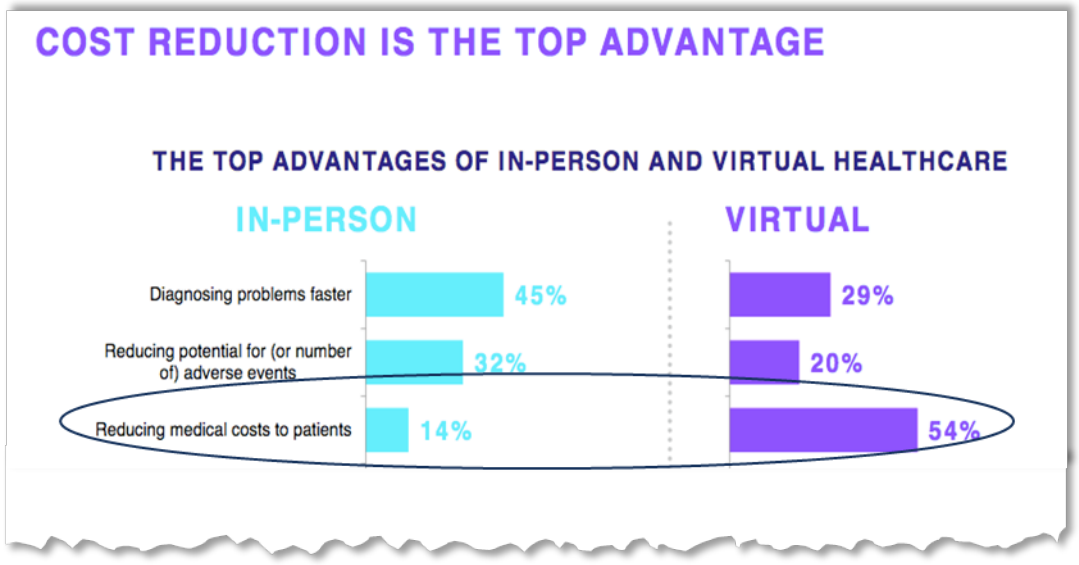
Proactively address unanticipated consequences

Plan and respond to questions and concerns

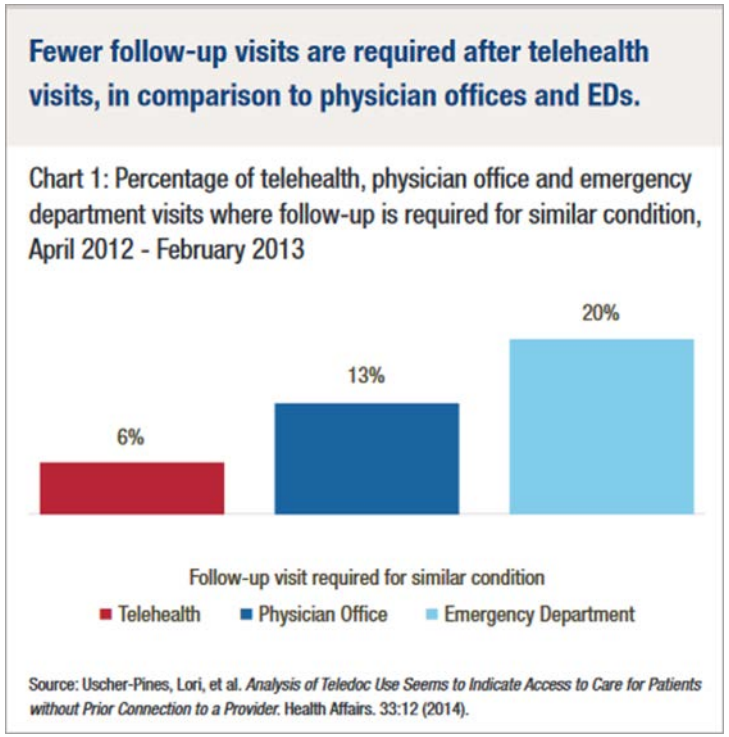
MYTH #1: TELEMEDICINE IS ONLY FOR RURAL AREAS

MYTH #2: TELEMEDICINE IS MORE EXPENSIVE

Telemedicine can be an effective tool to triage patients and redirect to more appropriate, less costly venues for care

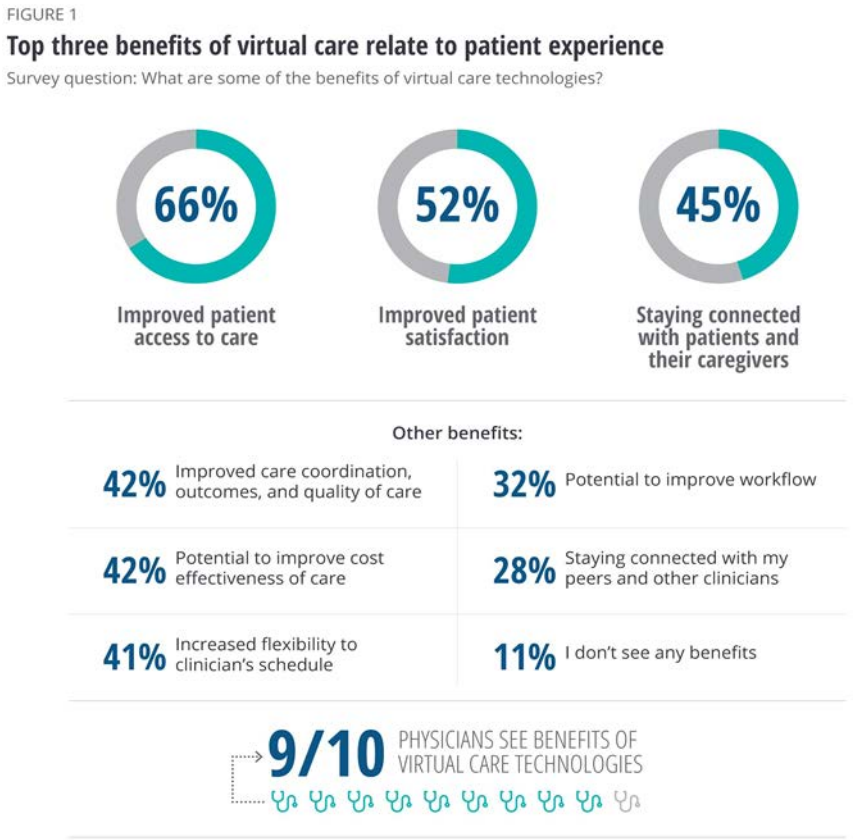


Source: 2018 Accenture Consumer Survey on Digital Health



MYTH #3: TELEMEDICINE IS NOT HIGH QUALITY

Telehealth increases patient feelings of personal involvement in their own care

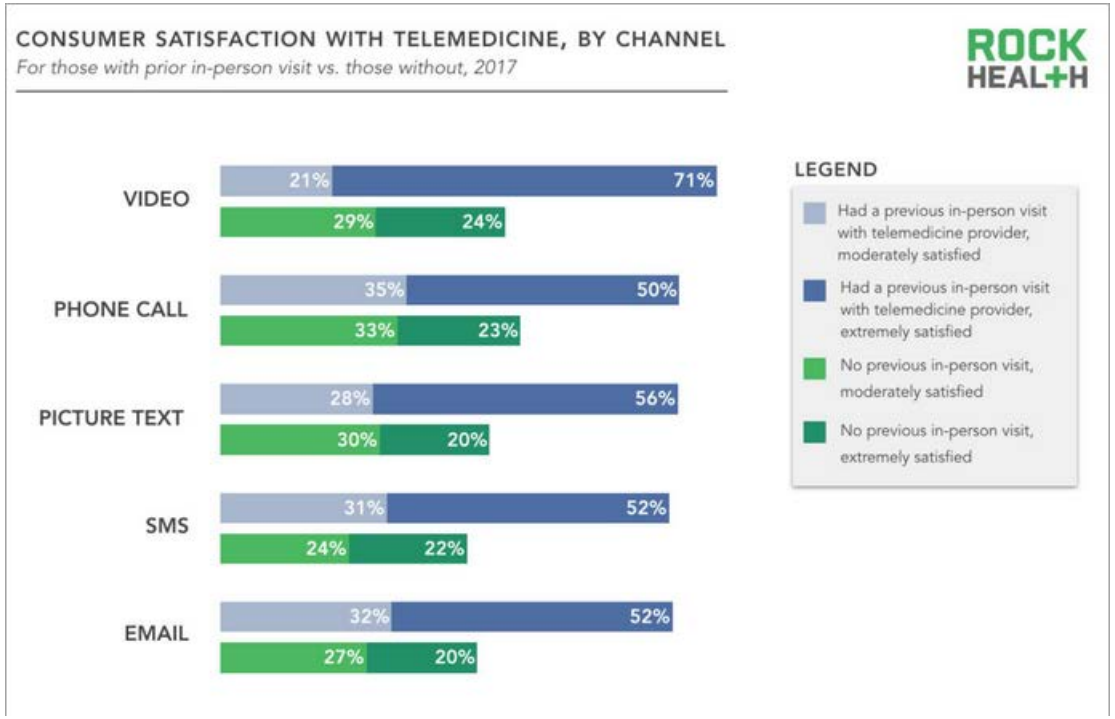


Source: Deloitte 2018 Survey of US Physicians

MYTH #4: TELEMEDICINE IS IMPERSONAL

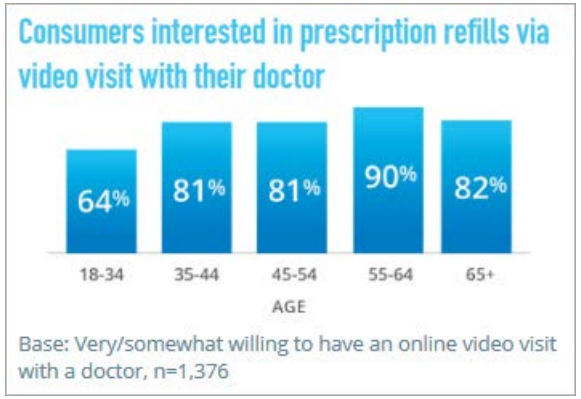
Data shows that the patients' perception changes once they have experienced the technology

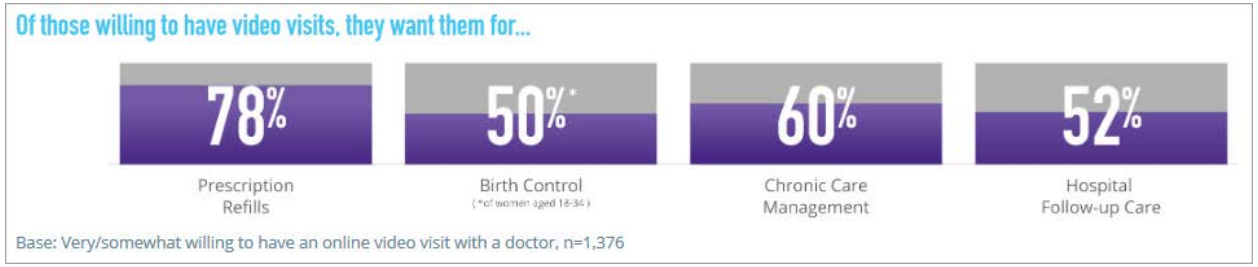
92% of patients with a prior in-person visit were satisfied with their video visit, as compared to 53% satisfaction among those without a prior in-person visit



MYTH #5: PROVIDERS PRESCRIBE MORE DRUGS WITH TELEMEDICINE

Telemedicine channels are bound by the same regulations and checks as when patients are seen in-person





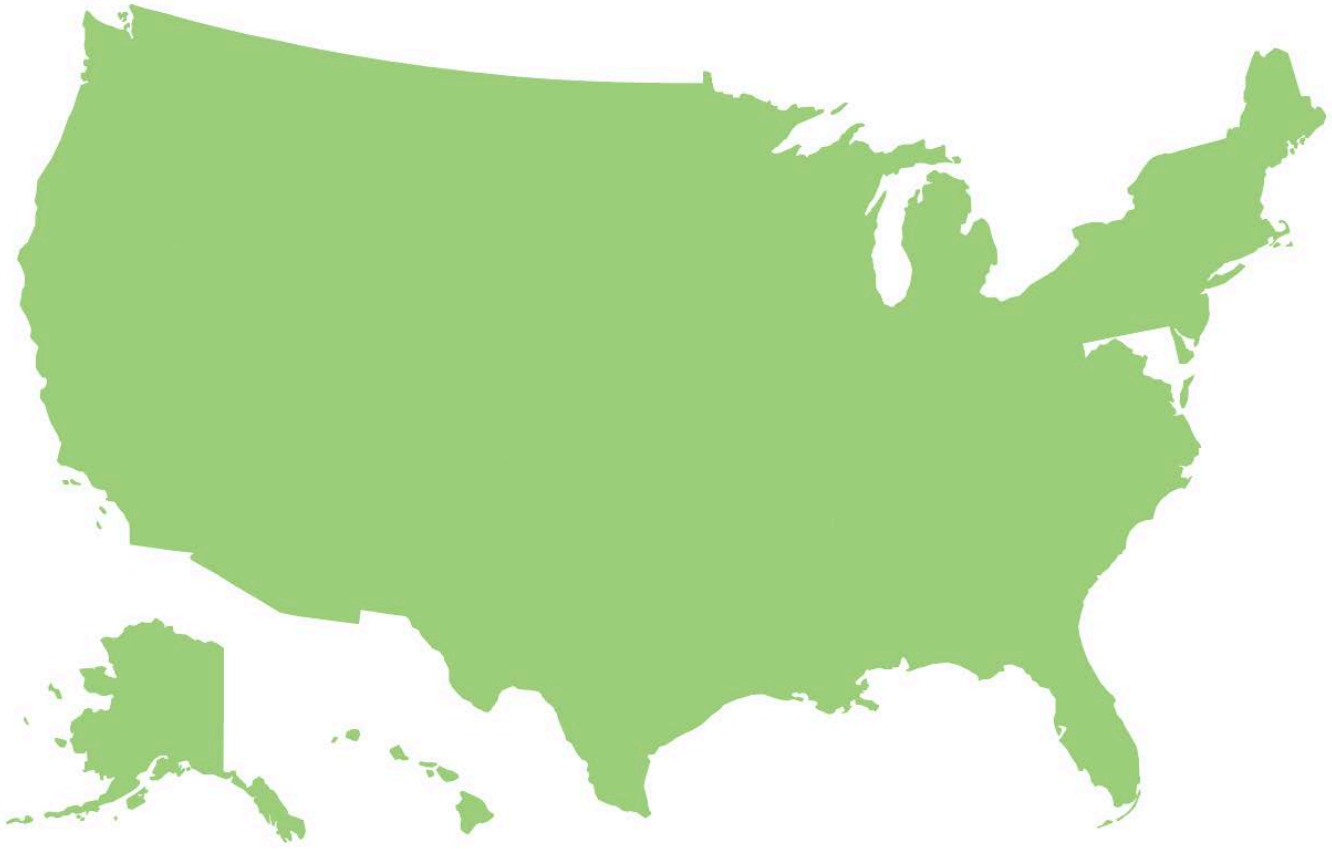
MYTH #6: TELEMEDICINE IS A THREAT TO PROVIDERS

MYTH #7: TELEMEDICINE IS ONLY SYNCHRONOUS COMMUNICATION

Asynchronous communication optimizes the telemedicine platform

Provider to Patient	Telehealth Modalities	Provider to Provider
Virtual Visits	Real-time virtual visits	eConsults
Wearables	Remote Patient Monitoring	Implantables
Secure Messaging	Asynchronous store-and-forward	Second Opinion Consults

THIS IS SUCCESS



Thank You

Ann Mond Johnson
ann@americantelemed.org

BIO

Matt Bell
Regional Vice President in Idaho, PacificSource

Hilary Klarc CPC-P
Director of Provider Network
& IPN Executive Director

27 May 2020

TeleT
Telehealth Task Force

PacificSource HEALTH PLANS

Telehealth Task Force
Subject Matter Presentation

Presented By:
Matt Bell, Regional VP of Idaho
Hilary Klarc, Director of Provider Network

Key Facts about PacificSource

- Not-for-profit public benefit corporation
- Headquartered in Springfield, Oregon
- Offices in Springfield, Eugene, Portland, Bend, Salem, Medford, Boise, Idaho Falls, Helena, Billings, Tacoma, and Spokane
- 500,000 members
- 1,435 employees
- Annual Projected 2020 Revenue of $2.7B
- Licensed in Oregon, Idaho, Montana and Washington
- Full range of Commercial, Medicare Advantage and Medicaid products
- Operate CCO's (Medicaid managed care) in Central Oregon, Columbia Gorge, Lane and Marion / Polk Counties
- Participating in Individual and SHOP exchanges in Oregon, Idaho, Montana and Washington

Our Mission, Vision, Values and Strategy

Our Mission is grounded in the Triple Aim, our Vision is to be the lifelong trusted partner, and our Values guide us in our work.

Mission	To provide better health, better care, and better cost to people and communities we serve
Vision	To be the lifelong trusted partner of our members and communities, helping to improve their health, wellbeing, health care experience and access to affordable health care.
Values	• We are committed to doing the right thing. • We are one team working towards a common goal. • We are each responsible for our customer's experience. • We practice open communication at all levels of the company to foster individual, team and company growth. • We actively participate in efforts to improve our communities, internal and external. • We encourage creativity, innovation, continuous improvement and the pursuit of excellence.
Strategy	We will achieve our vision by: • Convening and collaborating with our provider and community partners. • Integrating health care and community resources, technology and innovative approaches. • Engaging and investing in our communities • Continually improving the member experience

Telehealth Myths

- It’s Too Expensive
- I Don’t Have IT Resources
- I Don’t Have Time
- Patients Won’t Use It
- Insurance Won’t Pay For It

https://www.mgma.com/resources/health-information-technology/5-myths-of-telehealth

Telehealth Policy – PacificSource Definitions

- **Telehealth:** the provision of healthcare remotely by means of telecommunications technology *in real time*.
  - Covered for both telephone only and video/audio (FaceTime, Zoom, etc).
  - Typically **same** evaluation & management or psychotherapy services as done in an **office setting**.
- **E-visits:** communication between a patient and providers through an online patient portal or e-mail, *not in real time*.
- **Telephone Check In:** brief communication via telephone to determine if expanded office/telehealth/other service are needed between established patients and practitioners.

PacificSource Telehealth Policy Determinations

Subject Area	PacificSource Policy
Typical **Office Visit** Services Reimbursable/Covered **via Telehealth**	Covered
Telehealth Services **paid at Parity** with Office Visit Services	Covered
E-visits and Brief Telephone Check Ins	Covered
Originating Site: **Patient Home**	Covered
Expansion of Eligible Providers	Covered
Telehealth Modality (FaceTime or Skype etc)	Covered

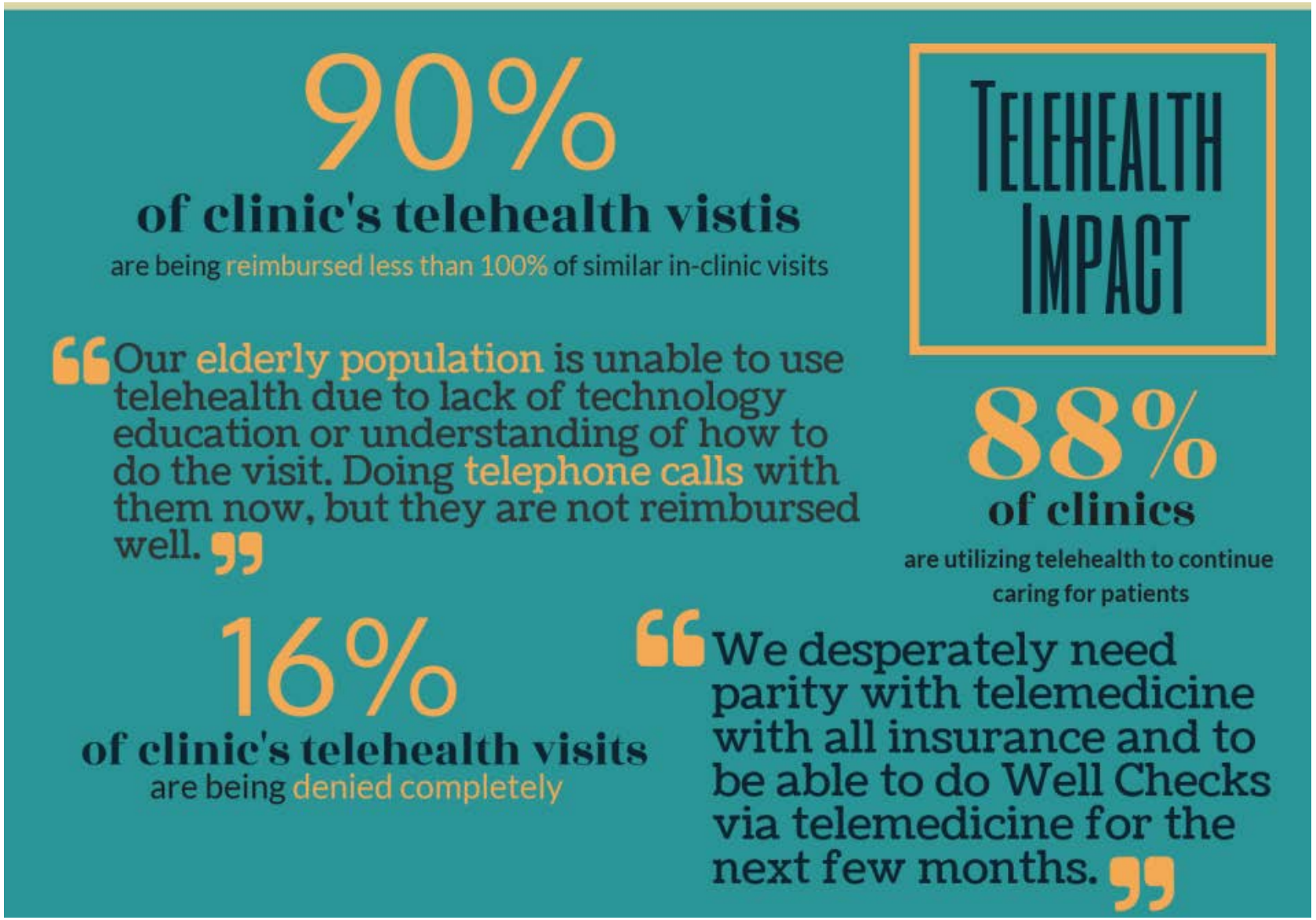
PacificSource Commercial Telehealth Top Billed Services

CPT Code	CPT Service Description	% of total*
90837*	Psychotherapy, 60 minutes with patient	31%
99213*	Office/Op Visit, Est Pt, 2 Key Components: Expand Prob Hx; Expand Prob Exam;Med Decision Low Complex	17%
99214*	Office/Op Visit, Est Pt, 2 Key Components: Detailed Hx; Detailed Exam; Med Decision Mod Complexity	13%
90834*	Psychotherapy, 45 minutes with patient	7%
99441	Telephone Evaluation and Management Service Provided by a Physician; 5-10 Minutes of Medical Discussion	5%
99212*	Office/Op Visit, Est Pt, 2 Key Components: Prob Focus Hx; Prob Focus Exam; Strtfwd Med Decision	3%
99442	Telephone Evaluation and Management Service Provided by a Physician; 11-20 Minutes of Medical Discussion	2%
90833*	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	1.9%
Other CPTs	Other Eligible Services	20%

**PacificSource Commercial line of business*

Impact of COVID-19 on Idaho Medical Practices

164 Idaho Provider Clinics responded to Survey.



**Thank you to IMGMA, IMA, IDID, & MedMan for their contributions in collecting this data.*

PacificSource Efforts to Support Telehealth

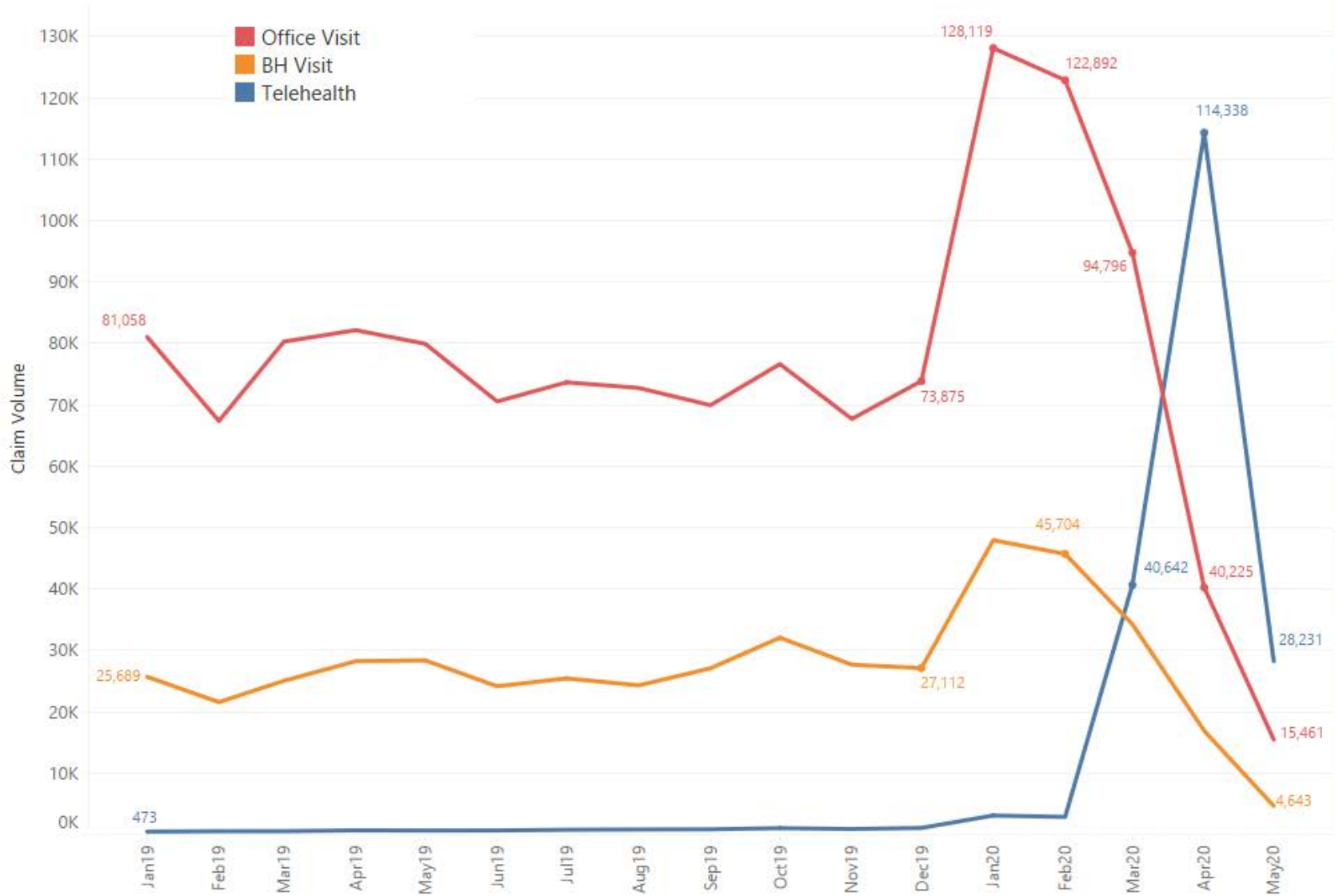
- Continue to allow **broad Telehealth coverage** performed by providers in our communities.
- Continue to **reimburse** Providers for telehealth services the same as if done in an office setting (at parity).
- Continue to **provide education** to Providers and members on our policies and **enhanced coverage** of telehealth.
- Continue to **closely monitor** telehealth claims weekly before payment goes out to ensure **accuracy**.
- PacificSource provided more than **$2 million** to participating providers across our service areas through our **Community Health Excellence Grant Program**. A majority of those funds were used to help providers transition or enhance telehealth:
    - Software Licenses, technology improvements, Internet Bandwidth, tablets or computers.
    - Some purchased additional tablets to loan out to their patients that don’t have telehealth access.

Dashboard Time Frame

Min Date	Max Date
2019-01-01	2020-05-16

Visits Volume & Telehealth Volume

Visit Data Pulled by Service Date, Office Visits (99201-99215) , BH Visits (90832-90838)
Telehealth Data Pulled by Service Date, Telehealth CPTs, Modifiers (GT ,GQ, 95), POS = Telehealth (02)



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MY (Date Filter)
All

Member State
All

Member County
All

Bus Seg 1
All

Bus Seg 4
All

Tax Name
All

CPT/HCPCS
All

Claim Status Code
All

Dashboard Time Frame

Min Date
2019-01-01

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Visits Volume & Telehealth Volume

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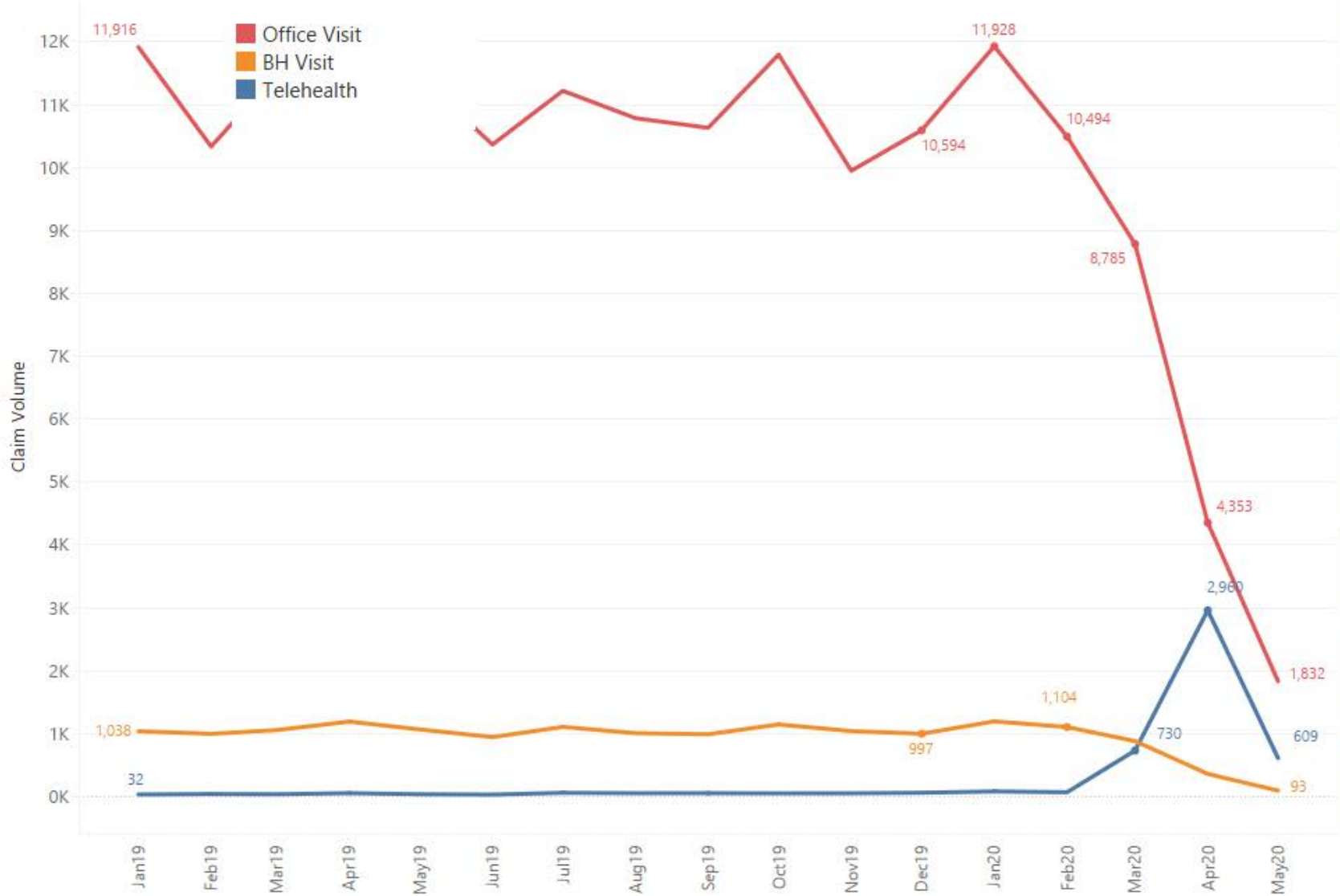


FILTER HERE

MY (Date Filter)
All

Member State
Idaho

Member County
All

Bus Seg 1
All

Bus Seg 4
All

Tax Name
All

CPT/HCPCS
All

Claim Status Code
All

PacificSource Idaho - Observations

- PacificSource is seeing **significantly less** Telehealth services billed for Idaho compared to other services areas: Oregon, Montana, and Washington. Common feedback include:
  - Patient demographics and technology capability
  - Provider delays in rolling out services
  - Outdated technology
  - Expensive software costs
  - Broadband Issues
  - Idaho's PCP and Behavioral Health Access Capacity
- PacificSource is monitoring closely Member/Provider experience and assessing all possibilities:
  - CMS requires the video component to be considered risk adjusted for Medicare Advantage and QHP plans.
  - CMS increased reimbursement for telephone only services.

Questions?

Contact Information:

Matt Bell, VP Idaho Regional Director

Matt.Bell@pacificsource.com

Hilary Klarc, Director of Provider Network

Hilary.Klarc@pacificsource.com

BIO

Julia Millard has been helping introduce new technologies to the healthcare industry for more than 15 years, including six years of Healthcare IT implementation experience at Epic and more than seven years in healthcare IT consulting and operational experience at one of the country's largest health systems. With a passion for improving the care experience for patients and providers alike, Julia has helped healthcare systems implement innovative tools and game-changing systems.

At Bright.md, Julia combines her expertise in change management, operational excellence, marketing and communications, system workflows, and stakeholder engagement to drive widespread adoption of virtual care programs at healthcare systems across North America.

27 May 2020

TeleT
Telehealth Task Force

Julia Millard

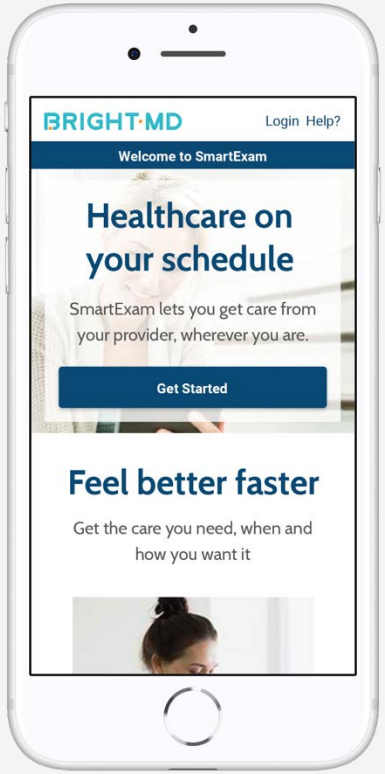
Healthcare Delivery Boost Leveraging Telehealth for Active Outreach in a Post COVID-19 Era

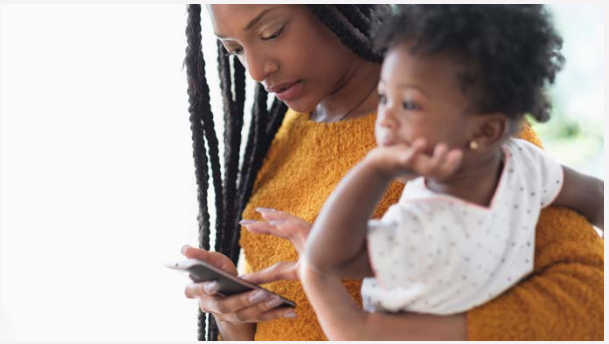
May 27, 2020

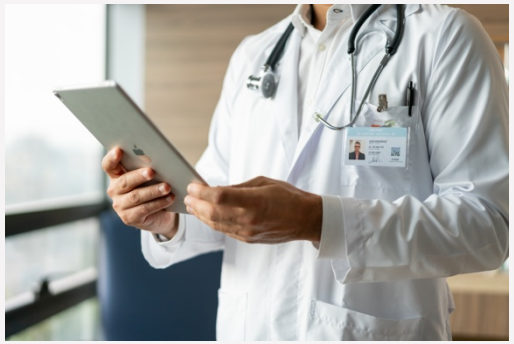
Bright.md

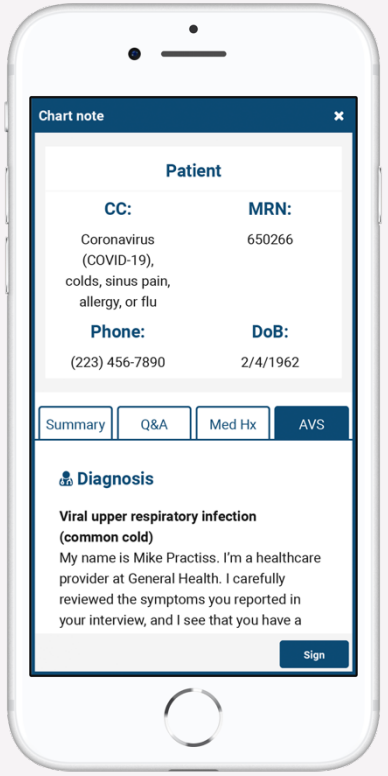
About Bright.md

Virtual care delivery, for the moment and the future.









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Executive Summary

Healthcare Delivery Boost

Leveraging Telehealth for Active Outreach in a Post COVID-19 Era

What We Can Learn from COVID-19

- Exposure in gaps in public health, clinical capacity, and emergencies
- Business landscape shift
- Stress on front-line staff

To Overcome Barriers in Idaho

- Implementing value-based payment models
- Managing heath across large rural geography
- Interoperable Data
- Improving performance and reporting

BRIGHT·MD

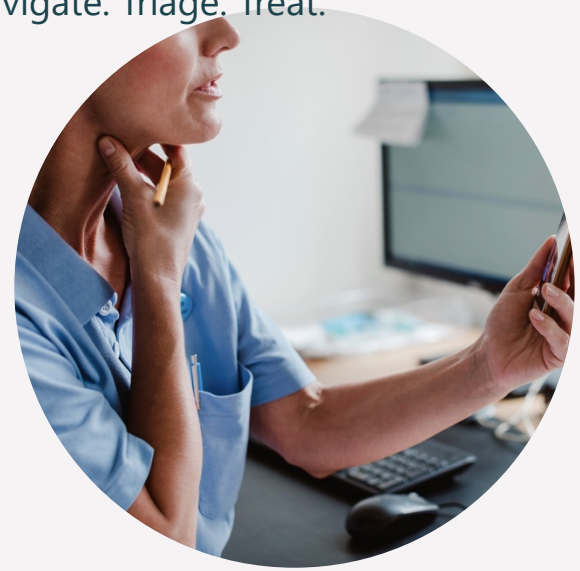
Magic Wand

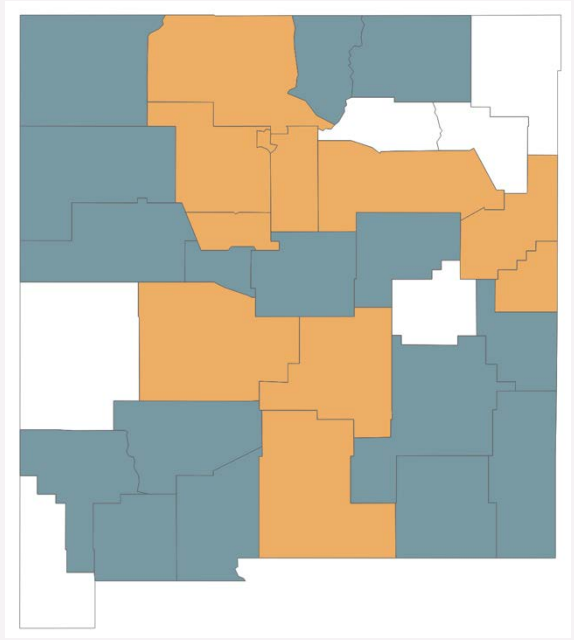
Healthcare Delivery Boost

Leveraging Telehealth for Active Outreach in a Post COVID-19 Era

The right mode at the right time.

Navigate. Triage. Treat.





The importance of providers.

Let's make their lives easier.

Telehealth in Rural Communities.

Realizing the benefits of remote care delivery.

BRIGHT·MD

Magic Wand

Healthcare Delivery Boost

Leveraging Telehealth for Active Outreach in a Post COVID-19 Era

Policies, Regulation, and Legislation

- Should favor all modes of telehealth including synchronous and asynchronous
- Telehealth coverage parity

Stakeholder Agreement Across the Entire Healthcare System

- With clear outcomes, supporting processes, and evaluation metrics

Adoption

- Focus on your innovation process and work with trusted advisors
- Make all modes are available, integrated and accessible at the right time
- The solutions must be effective for patients to receive care
- Options should be affordable for patients
- Build trust and engagement by branding the solutions to your healthcare system

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Conclusion

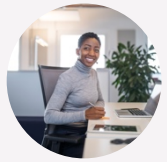
Healthcare Delivery Boost

Leveraging Telehealth for Active Outreach in a post COVID-19 Era

Key Benefits

A successful telehealth program will help you lead through the gaps and changes we are experiencing today for a better future.

Navigate. Triage. Treat.

Patient	Provider	Payer
		
Reduced Costs	More efficient and improved care delivery quality	Reduced costs
Improved Satisfaction, Retention, and Loyalty	Expanded patient base and trimmed costs	Increased population health
Expanded Access, Convenience and use	Reduced burnout by greater flexibility and automation	Better quality

BRIGHT·MD

Questions?

Thank You!

Julia Millard
VP of Customer Success
Bright.md
julia@bright.md

Biography

For more than 15 years, Julia Millard has been helping introduce new technologies to the healthcare industry, including six years of Healthcare IT implementation experience at Epic and more than seven years in healthcare IT consulting and operational experience at one of the country's largest health systems. With a passion for improving the care experience for patients and providers alike, Julia has helped healthcare systems implement innovative tools and game-changing systems. At Bright.md, Julia combines her expertise in change management, operational excellence, marketing and communications, system workflows, and stakeholder engagement to drive widespread adoption of virtual care programs at healthcare systems across North America.

BRIGHT·MD

Telehealth Task Force

Use Case Name: Healthcare Delivery Boost - Leveraging Telehealth for Active Outreach in a Post COVID-19 Era

Presentation Date: May 27, 2020

Presenter: Julia Millard, Bright MD
Presenter Email: juli
510 SW 3rd Ave #300 Portland, OR 97204
Phone: 877-888-5242

Use Case Description:

The COVID-19 pandemic has forced us how to re-think the way healthcare is delivered. The pandemic has not only exposed gaps in public health, clinical capacity, and emergency situations; it has shifted the business landscape for systems and put additional stress and pressure on front-line staff. As we move forward into the new frontier, focusing on new digital telehealth delivery models can help systems actively recover, add many benefits to mend the gaps, and boost adoption.

In this presentation, Julia Millard, VP of Customer Success at Bright.md will discuss:
- Key learnings from the COVID-19 crisis and how a successful telehealth program can overcome barriers.
- Innovative solutions to expand telehealth adoption in Idaho.
- Added benefits that can be realized from a successful telehealth program.

Accomplishments and Quick Wins:

Virtual care delivery helps facilitate the transition from fee-for-service (FFS) to value-based care (VBC) across a geographically dispersed and rural population. Done well, virtual care is data light, requiring no special equipment or broadband access, and ensures all data is interoperable, managing health across a large rural geography, and improving the performance and reporting of a care delivery system. To successfully do this, policies, regulation, and legislation need to favor all modes and types of telehealth solutions including synchronous and asynchronous options. By favoring all modes and types of telehealth solutions, healthcare systems and providers will feel empowered to implement the right solution for the right use case with a strategy that meets the needs of providers, patients, and payers. Stakeholders across the healthcare system need to be in alignment with clear outcomes, processes,

and evaluation metrics. Lastly, in order for providers to build trust across their network, the solutions should be effective for patients to receive care, affordable for patients, and branded to the healthcare system that is delivering the care.

In the first three months of 2020, Bright.md's customers experienced more patient visits than the entire 2019 calendar year on our virtual care automation platform. In rural geographies, we've been able to expand access while increasing patient and provider satisfaction, as well as adherence to evidence-based standards. We have witnessed providers being able to treat patients 90% faster (2 minutes vs 20 minutes) and the care cue for patients decrease from waiting as long as four hours for an in-person visit to 6 minutes.

Best Practices, Lessons Learned and A-Ha Moments (lessons learned):

By automating the burdensome administrative tasks clinicians deal with (charting, order entry, coding, billing) and keeping providers out of clunky EMRs, providers can deliver care with a few clicks, from anywhere at anytime in less than two minutes. This creates efficiencies and a better experience for patients, providers, and payers, facilitates a comprehensive continuum of care for patients, and frees providers to spend time with patients who have more complex medical conditions.

Barriers and Challenges

Virtual care delivery helps facilitate the transition from fee-for-service (FFS) to value-based care (VBC) across a geographically dispersed and rural population. Done well, virtual care is data light, requiring no special equipment or broadband access, and ensures all data is interoperable, managing health across a large rural geography, and improving the performance and reporting of a care delivery system.

What is your magic wand scenario?

Focusing on key outcomes across the entire care continuum, healthcare systems and providers will be able to easily utilize the right telehealth mode at the right time and monitor the success and performance over time. Telehealth should also be leveraged for active outreach in rural communities to make it easier, accessible, and convenient for patients and providers. From the provider standpoint, clearly understanding the workflows and frustrations providers have around electronic record management (EMR) and other administrative tasks can help drastically streamline the care delivery process.

Recommendations:

Policies, regulation, and legislation need to favor all modes and types of telehealth solutions including synchronous and asynchronous options. By favoring all modes and types of telehealth solutions, healthcare

systems and providers will feel empowered to choose the right solution for the right use case with a strategy that meets the needs of providers, patients, and payers. Stakeholders across the healthcare system need to be in alignment with clear outcomes, processes, and evaluation metrics. Lastly, in order for providers to build trust across their network, the solutions should be effective for patients to receive care, affordable for patients, and branded to the healthcare system that is delivering the care.

BIO

Dr. Sarai Ambert-Pompey received her medical doctorate at Ponce Health Sciences University. She completed a post-doctoral fellowship at Oregon Health and Science University in neuro-oncology, and internal medicine training at the Boise Internal Medicine-University of Washington Residency Program. She is currently a general internist at the Boise VA with the VISN 20 Clinical Resource Hub working with rural and underserved Veterans in the northwest area.

As part of the Center of Education for Interprofessional Collaboration since 2015, Dr. Ambert-Pompey focuses on health professional trainee education in primary care and provision of care via telehealth modalities. Her interests are home/work balance, diversity and inclusion, leveraging technology and efficiency strategies while balancing a humanistic approach to shared-decision-making and team-based care.

27 May 2020

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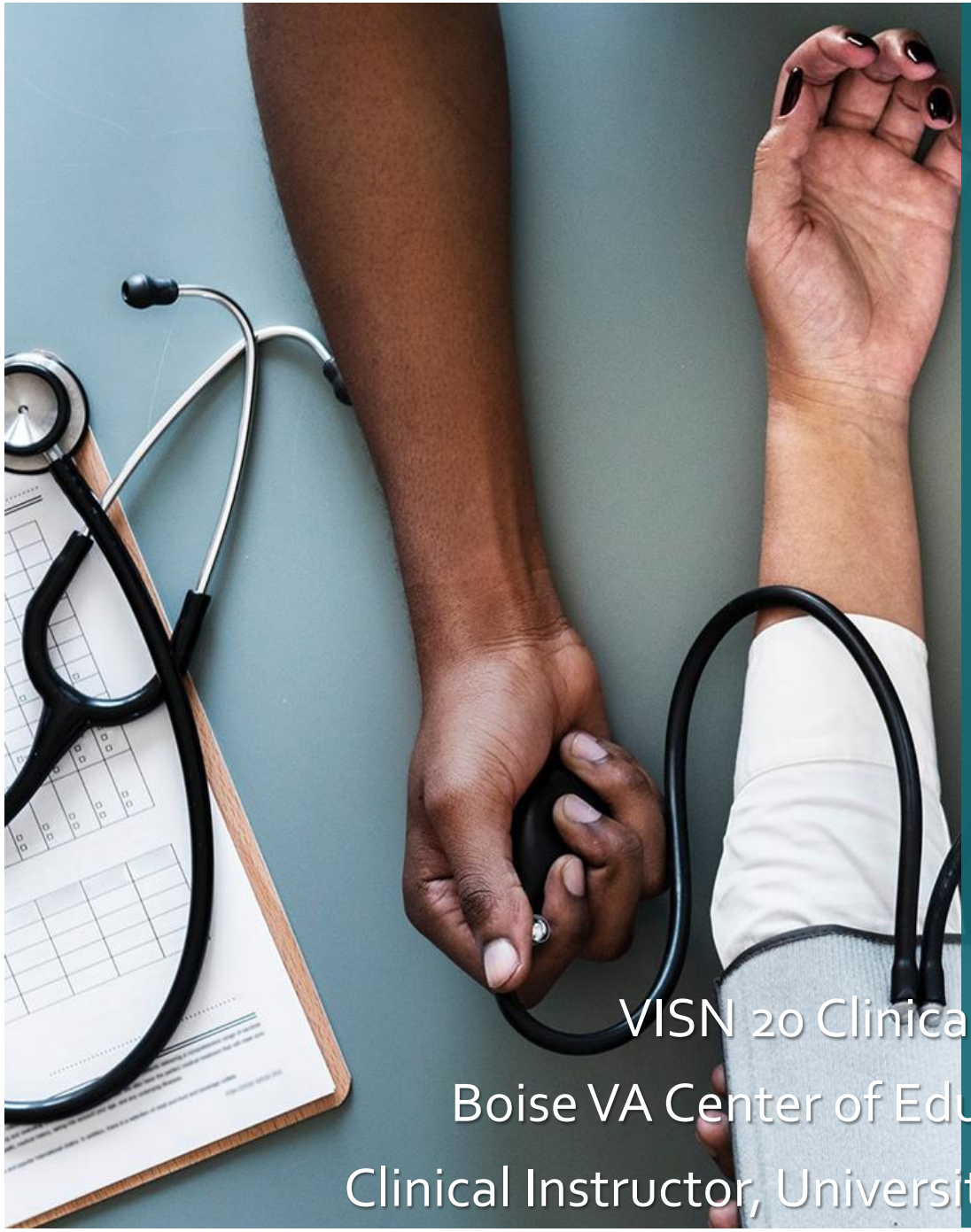
Telehealth Task Force



Sarai Ambert-Pompey, MD

Telehealth Task Force Telehealth Interprofessional Education

Wednesday, May 27th, 2020

Boise VA Medical Center

VISN 20 Clinical Resource Hub, TelePrimary Care Manager

Boise VA Center of Education and Interprofessional Collaboration

Clinical Instructor, University of Washington, Department of Medicine

About Us:

Dr. Ambert-Pompey received her medical doctorate at Ponce Health Sciences University. She completed a post-doctoral fellowship at Oregon Health and Science University in neuro-oncology, and internal medicine training at the Boise Internal Medicine-University of Washington Residency Program. She is currently a general internist at the Boise VA with the VISN 20 Clinical Resource Hub working with rural and underserved Veterans in the northwest area.

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Executive Summary of our Case Study

Multidisciplinary comprehensive telemedicine workplace learning curriculum for Boise UW Internal Medicine and VA Nurse Practitioner Residency Programs 2019-2020

The clinical experience: patients via medical home primary care to a rural clinic, to a telehealth station, and to home or mobile device

A total of 17 trainees rotated, including 14 internal medicine residents (3 Post-Graduate Year (PGY) 3, 5 PGY2, 6 PGY1) and 3 nurse practitioner residents (PGY1).

Total 36 telemedicine visits: 25 clinic to clinic and 11 to local access station, home or mobile (6 during the rotation and 5 after)

Telemedicine education to faculty, residents and students needs to expand to meet the expectations after completing training as telehealth expand in many healthcare settings. Policy and reimbursement should be consistent with that

Patient

Patient View

Magic Wand Scenario:

Expand faculty development, undergraduate and graduate telemedicine curricula

Ideally, telemedicine training should be in a spectrum of competencies building on over time starting at the undergraduate throughout graduate level. However, in many places faculty and post-graduate trainees had no workplace telemedicine training experiences. By catching up at this level the information load is larger. Whereas if integrating telemedicine training experiences at the undergraduate level we hope training can be in a spectrum building on over time.

Magic Wand:

Telemedicine is a great tool to integrate to any outpatient practice in primary care and specialty care. However, we need to learn how to provide it safely and how to teach it effectively in those settings.

We need to strengthen undergraduate and graduate medical education to continue to expand telemedicine education to meet the current and future needs to make education for our trainees comprehensive and complete.

Didactics, simulations and workshops can be use to train the trainer to disseminate.

We need to continue parity of reimbursement for telemedicine after the COVID19 crisis ends. Future state level policy telehealth policy needs to take into considerations undergraduate and graduate medical education to continue to make provisions to encourage telemedicine education.

Summary Conclusion:

Multidisciplinary comprehensive telemedicine workplace learning curriculum for Boise UW Internal Medicine and VA Nurse Practitioner Residency Programs 2019-2020

Telemedicine education to faculty, residents and students needs to expand to meet the expectations after completing training as telehealth expand in many healthcare settings.

Reimbursement and healthcare policy need to take into consideration provisions to expand telemedicine education at the undergraduate, graduate and faculty levels.

Contact Information:

Sarai.Ambert-Pompey@va.gov

Telehealth Task Force

Use Case Name: Telemedicine Curriculum for Graduate Medical Education

Presentation Date: May 27th, 2020

Presenter: Sarai Ambert-Pompey, MD

Presenter Email: Sarai.Ambert-Pompey@va.gov

Use Case Description:

Telemedicine is a growing aspect of health care delivery in the United States (US) with use in over 60% of healthcare institutions prior to COVID-19. Since the COVID-19 pandemic started, increased reliance on telemedicine has resulted in fundamental changes to reimbursement which will undoubtedly change the landscape in the future. However, no published literature exists in the US on structured workplace-based telemedicine curriculum in graduate medical education.

Using the Kern's approach, a multi-disciplinary telemedicine curriculum was developed at the Boise Veterans Affairs Medical Center (VAMC) between July 2019 and May 2020. This week-long ambulatory elective included trainees from the University of

Washington Boise Internal Medicine Residency and the Nurse Practitioner Residency. The clinical experience involved patients via rural Clinic Video Telehealth (CVT), an Accessing Telehealth through Local Area Stations (ATLAS) in a highly rural location and to patient's home or mobile using VA Video Connect (VVC).

A total of 17 trainees rotated, including 14 internal medicine residents (3 Post-Graduate Year (PGY) 3, 5 PGY2, 6 PGY1) and 3 nurse practitioner residents (PGY1).

Accomplishments and Quick Wins:

Qualitative evaluation of the telemedicine curriculum was completed via post-rotation survey that assessed self-rated skills in telemedicine and applicability to future practice. The program evaluation included tracking the numbers of the trainee's telemedicine unique visits during and after the rotation. Telephone visits were not tracked.

Trainees completed a total of 36 telemedicine visits. Of these, 25 were clinic to clinic CVT and 11 were video to home or mobile VVC. Of the VVC visits, 6 were completed during the rotation and 5 were completed after the rotation. All trainees completed clinic-to-clinic telemedicine visits, but only half completed clinic-to-home telemedicine visits.

Comments from trainees ranged from "wish I had this rotation earlier" to "I will consider primary care now" and "the rotation has a lot of information and the pace is very appropriate to internalize it and build on it."

Our curriculum has become a national model adapted in many other VA academic training clinics in the US.

Based on success of the primary care telemedicine curriculum, a telemedicine project featuring group visits for diabetes education was developed and provides further opportunity for study.

Best Practices, Lessons Learned and A-Ha Moments (lessons learned):

- We need to trained all providers (trainees and faculty) to learn use this tool.
- Emphasis needs to be placed on generalizable telemedicine concepts: requirements, policy, emergency plan and the differences between face to face visits and video visits: telepresence (professionalism, communication and observe behavioral cues, gaze angle)
- Simulations are helpful to walk through the patient experience and to try the technology before the provision of telemedicine care.
- Workplace learning in clinic providing telemedicine care solidifies the training experience

Barriers and Challenges:

- Limitations to full participation by trainees included technology related and changes to practice protocols due to COVID-19. We continue to work in partnership with our facility telehealth and Information Technology (IT) departments.
- Once COVID19 change the amount of telehealth provided in outpatient care, another limitation was most of the faculty were trained to provide telemedicine but not trained to precept video encounters. We provided a timely faculty development in-service to address a few skills to precept using telehealth technology.
- Clinic workflow with trainees is slower compared to a clinic without trainees due to dedicated time to staff the patients with the attending physicians. Teaching workplace learning telemedicine provision can slow the clinic even more due to

telehealth skills learning curve and potential technical difficulties. Simulations help the trainees feel comfortable with the technology. We mitigate some workflow problems doing a weekly meeting discussing the patients of the week including which patients the trainees will see. We try to aim for a schedule that alternates telephone and video telemedicine visits.

What is your magic wand scenario?

Acknowledging the foundational nature of VA telemedicine curriculum in primary care, future curricula areas of study will be integration of telemedicine into other settings – including non-VA primary care settings and subspecialty practice with trained faculty. Future telehealth policies will continue to be consistent with moving telemedicine education forward.

Recommendations:

Telemedicine is a great tool to integrate to any outpatient practice in primary care and specialty care. However, we need to learn how to provide it safely and how to teach it effectively. We need to strengthen undergraduate and graduate medical education to continue to expand telemedicine education to meet the current and future needs to make education for our trainees comprehensive and complete. We need to continue parity of reimbursement for telemedicine after the COVID19 crisis ends. Future state level policy telehealth policy needs to take into considerations undergraduate and graduate medical education to continue to make provisions to encourage telemedicine education.

BIO

Dave Hays is a program specialist with the Idaho Bureau of EMS and Preparedness, where he manages the state's Community Health Emergency Medical Services (CHEMS) program. Prior to joining the state of Idaho in early 2019, Dave enjoyed a twenty-six-year career in natural resources and public lands management, retiring from the US Forest Service.

Throughout his federal career, Dave also served as a part-time and volunteer firefighter and EMT, working in numerous rural communities in three western states. Dave's early professional life included a brief stint as a junior high school teacher of English and math in his hometown, Sacramento, California.

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Telehealth Task Force

Dave Hays
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Telehealth and Community Health EMS--The Potential to Transform

May 27, 2020

Idaho Bureau of EMS and Preparedness

About EMS and Community Health EMS…

Then, Now, and into the Future

What if we move beyond transportation to transform healthcare…?

Transforming healthcare through CHEMS, it's about…

Meeting patients where they are

Filling gaps

Solving problems and eliminating barriers

Magic Wand Scenario

Emergency care, primary care, transitional care gaps are filled by CHEMS providers, connected through telehealth to the larger healthcare system.

Current barriers include…

The reimbursement landscape for EMS/CHEMS and the fee for service model

The unknowns surrounding telehealth from privacy to payment to purpose and benefit

If you wave the wand hard enough, AND…

Move mountains like..

Move to Value—incentivize keeping patients healthy rather than pay only to treat their illnesses

Or maybe start smaller…

Make permanent the COVID-19 approach to telehealth

Pay EMS to employ telehealth on a 911 call

Reimburse CHEMS services to Idaho Medicaid patients

In the end…

EMS/CHEMS will reach the patient, solve problems, and connect to care. Let's use telehealth to help that happen!

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Telehealth Task Force
Use Case Name: Telehealth and Community Health EMS—The Potential to Transform
Presentation Date: May 27, 2020

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Use Case Description:
Historically, emergency medical services (EMS) was simply a transportation service, moving victims of injury and illness to a hospital. As systems evolved, those driving ambulances and providing first aid gained increased training, eventually leading to our current system of emergency medical technicians and paramedics. Along with the evolution of care, so evolved communications between EMS providers and hospitals. What started as a phone call or a radio transmission, evolved into more sophisticated transmission of data from the field to the emergency department. These communications are varieties of telehealth and telemedicine, extending the reach of the emergency physician into the field. In many ways, EMS systems were pioneers in telehealth and telemedicine.

Today, EMS leaders seek to serve as active agents of change, reforming and transforming the healthcare system to improve patient outcomes, enhance population health, and reduce the cost of healthcare. With those goals in mind, community health emergency medical services (CHEMS) has developed. CHEMS providers are emergency medical technicians (EMTs) and paramedics with additional specialized training to serve patients in non-traditional roles. In these roles, they extend the reach of primary care providers, visiting patients at home. The roles they play are varied and based on the needs of the community and patient. For example, in some cases, CHEMS providers connect with patients who are high utilizers of the 911 system to address underlying unmet health needs that lead to excessive calls for assistance. In other cases, CHEMS providers may help with transitional support after hospital discharge, assuring patients transition back into their homes with a good understanding of how to manage their health through this transition. CHEMS work, of course, occurs in close coordination with primary care providers, as well as other healthcare professionals like discharge planners.

With the broad work of CHEMS programs, the opportunities to integrate telehealth are numerous. Examples include:

- Supporting patients with chronic conditions--CHEMS providers are present during a telehealth visit in a patient's home, with the primary care provider (PCP) connecting from a remote location.
- Arriving in a patient's home in response to a 911, finding a low-acuity condition, then initiating a telehealth visit with a provider--treating the patient in place or transporting them to an appropriate facility other than an emergency department.
- Making a routine CHEMS visit to a patient's home to find the patient suffering from new (but non-emergent) symptoms. Initiating a telehealth visit with the patient's PCP rather than transporting the patient to an emergency department.
- Reaching out to vulnerable populations (citizens experiencing homelessness, for example), initiating telehealth visits when discovering low-acuity conditions that could be addressed in the field.

Accomplishments and Recent Quick Wins--CHEMS and Telehealth in a Pandemic

We are seeing innovation and creativity by CHEMS providers in the face of COVID-19. For example:

- Shoshone Family Medical Center (SFMC) is leveraging their partnership with Lincoln County CHEMS. Rather than bringing patients into the clinic for their regularly scheduled appointments, SFMC sent community EMTs to patients' homes to facilitate telehealth visits. The result is decreased COVID-19 exposure for patients at risk, and success using community EMTs to facilitate visits for those who struggled with technology.
- Magic Valley Paramedics in Twin Falls are using their CHEMS staff to facilitate sound decision making when COVID-19 threatens skilled nursing facilities. By deploying CHEMS providers to nursing homes to assess patients with COVID symptoms, then looping in emergency physicians through telemedicine, they are avoiding unnecessary transports to emergency rooms. As a result, patients are receiving needed care in their own home, rather than making a disruptive, expensive, and perhaps even risky, trip to the emergency room.

Barriers and Challenges:

- Not as easy as it looks…questions like what platform to use, how to stay compliant and protect privacy, these all emerge once you start looking at a telehealth program.
- Current Fee for Service payment models often do not incentivize programs like CHEMS and innovations like telehealth.
- Until payers reimburse for CHEMS visits, it is tough to sustain a program, even when it makes sense to do so.
- CHEMS is meant to fill gaps, not duplicate services of other providers or programs. It is important to communicate and demonstrate this approach.

What is your magic wand scenario?

If I were to wave a magic wand over Idaho's EMS system—and Idaho's entire healthcare system—I would see CHEMS providers filling numerous gaps in our systems and communities. These providers would be using telehealth tools and techniques to connect their CHEMS patients with appropriate providers. In the end, it would be a well-connected healthcare system, moving populations toward greater health, helping patients better manage their own health, and reducing healthcare costs.

Recommendations:

- Make efforts to move to a value-based system of care, where it pays to keep patients healthy.
- Support efforts to reimburse for CHEMS visits and providers—it just makes too much sense no to!
- Extend and make permanent the current telehealth flexibilities made available by the CMS (during COVID-19).
- Make the commitment to transform EMS from a historic transportation provider, to a modern member of the larger healthcare system.